

# Community / Outpatient Referral to Nutrition and Dietetics Department



## All fields are mandatory for all referrals

If the information is unavailable, provide a reason or the referral will be returned.

<b>Patient Name:</b> <b>10 digit CHI No:</b> <i>Known as:</i> <span style="float: right;"><b>M / F</b></span> <b>Address:</b>  <b>Postcode:</b> <b>Daytime Tel. No:</b>	<b>Referrer Name:</b> <b>Designation/Job title:</b> <b>Address:</b>  <b>Postcode:</b> <b>Tel. No:</b>
<b>Able to attend clinic?</b> Yes      No*	<b>GP Name:</b> <b>GP Practice:</b>
<b>*If <u>no</u>, please tick preferred appointment type:</b>  <div style="text-align: right;">                     Home visit      <input type="checkbox"/>                      Telephone review with patient      <input type="checkbox"/>                      Telephone review with key contact      <input type="checkbox"/> </div>	<b>If patient is housebound is there any lone working risk when visiting at home?</b> <div style="text-align: right;">                     Yes      <input type="checkbox"/>      If <u>yes</u>, give details:                      No      <input type="checkbox"/>                      Not known      <input type="checkbox"/> </div>

<b>Baseline anthropometry:</b>	<b>Weight (kg):</b> <b>Height (m):</b> <b>BMI (kg/m<sup>2</sup>):</b> <b>MUST Score:</b> <i>(Those at risk of malnutrition)</i>	<b>Weight History</b> (kg):	<b>1 month ago:</b> <b>3 months ago:</b> <b>6 months ago:</b> <b>12 months ago:</b>
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<b>Reason for referral:</b>	<b>Relevant medication, allergies, blood results:</b>
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<b>Medical history:</b>
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<b>Details of first line advice carried out:</b> (e.g. food fortification, written / verbal advice given, onward referrals)
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<b>Additional relevant information:</b> (e.g. social factors, mental health issues, directions to house, details of key contact)
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I confirm that the patient/patient's representative has consented referral to the Nutrition and Dietetics Department and to details being held for clinical and administration purposes <input type="checkbox"/>	
<b>Referrer's signature:</b>	<b>Date:</b>

**Please post to:** Nutrition and Dietetics Department, Gilbert Bain Hospital, Lerwick, ZE1 0TB.  
 Or **email to:** [shet-hb.dietetics@nhs.net](mailto:shet-hb.dietetics@nhs.net)